Exhibit A
(Redacted)

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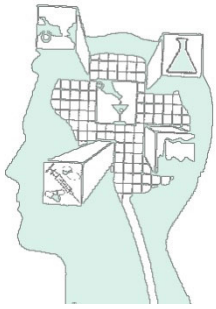

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NAME	**GARCIA,** JULIA *GARCIA V. WELLS FARGO*
CASE NO.:	1:20-cv-02402
AGE: DATE OF BIRTH:	54; [redacted]
EDUCATION:	M.A.
DATE OF EVALUATION:	May 12 2022
REFERRED BY:	**CHRISTOPHER M. PARKER,** Associate Attorney WINSTON & STRAWN LLP 35 W. Wacker Drive Chicago, IL 60601-9703
HOURLY FEE:	795.00/HR (EXPEDITED REVIEW, EXAMINATION, DEPOSITION AND TRIAL RATE)

CREDENTIALS: I am a board certified clinical psychologist and neuropsychologist, licensed in the State of Illinois with a Ph.D in Psychology from the University of Illinois, three Master's Degrees (MS Psychopharmacology-Alliant University, MA Psychology-University of Illinois, MA Psychology-Princeton University), AB-Vassar College. My internship/residency was at Michael Reese Hospital, Chicago Illinois. I am a Fellow of the National Academy of Neuropsychology. I have published and lectured in neuropsychology and psychology for many years and am the primary author of a new neuropsychological test: *Trails X,* published by Psychological Assessment Resources. These and other professional credentials are contained in my CV and attached to this document. I have testified as an expert on cases, the most recent 4-year period is listed in an appendix to this document.

REASON FOR REFERRAL: Ms. Garcia was referred for neuropsychological examination to determine current psychological and cognitive status in the context of litigation in the matter listed above. Information was requested on diagnosis(es), influences on diagnosis(es), current work or other limitations, if any, and treatment recommendations. These are contained in the following neuropsychological expert report for Julia Garcia. This report contains the complete set of opinions I intend to address in this matter, barring new information being made available for my consideration.

TESTS AND PROCEDURES

Shipley-2 Intelligence Test**,** Word Memory Test (WMT), Wisconsin Card Sorting Test (WCST); Battery for Health Improvement-2 (BHI-2); Minnesota Multiphasic Personality Inventory –3 (MMPI-3), Inventory of Problems-29 (IOP-29) Structured Inventory of Malingered Symptomatology (SIMS), Medical History Questionnaire, Personality Assessment Inventory (PAI), Clinical Interview

RECORD REVIEW

Records sent for my review include the following:
LISTZYGMUNT 00001 - 00013.pdf
VIRGILI 00179 - 00264.pdf
PILLAI 00501 - 02083.pdf
LYNCH 00091 - 00242.pdf
KIM 00001 - 00119.pdf
FRANK 00001 - 00048.pdf
FIKARIS 00001 - 00040.pdf
FEHR 00001 - 00026.pdf
NORBERG LOPEZ 00001 - NORBERG LOPEZ 00259.pdf
JULIA'S MED RECS 03323-03691.pdf
BANKOSLY 00001 - 00420.pdf
JULIA'S MED RECS 00001-03322.pdf
DEPOSITIONS of Julia Eduardo and Byron Garcia

Approximately 6500 pages of records for Ms. Garcia were made available for review, including records from Dr. Pillai, Elmhurst Memorial Hospital, Elmhurst Neuroscience Institute, Cook County Health, and Drs. Zygmunt, Virgili, Lynch, Kim, Frank, Fikaris, Fehr, Norberg and Bankosly. Records also included depositions of Byron, Julia and Eduardo Garcia. In the interest of brevity, information from available records is highlighted rather than comprehensively abstracted in this document. All available records have been reviewed prior to completion of this report.

The earliest medical record made available for my review was dated May 9, 2007 from Trinity Health/Elmhurst, which included a diagnosis of active chronic gastritis. Ms. Garcia also complained of sharp anterior chest pain symptoms about one hour prior to arrival, that radiated to the throat and which were aggravated by stress. She had been taking (antidepressant) Prozac for anxiety, but stopped. The examiner consulted with a Dr. Olga Garcia-Bedoya, who reported that Ms. Garcia's history was "strong for anxiety."

There are earlier medical records referenced, but original records were not made available. There is a reference to Ms. Garcia having been diagnosed with Fibromyalgia in 2006 per Elmhurst Memorial Hospital Pain Center records. Clinical history taken on March 6 2015 noted that Ms. Garcia survived a bus accident in Mexico. The accident occurred in 1986 and Ms. Garcia was required to remain in a cast for six months. After this event, she continued to have “issues.”

A September 2007 report from Trinity Health/McNeil Hospital includes a chief complaint of lower back pain. Ms. Garcia indicated that she injured her back many years ago after a car accident and that she has a history of fibromyalgia. There were no other complaints.

The Trinity Health/McNeil Hospital record of October 19, 2007 included an emergency room chief complaint of migraine headache and vomiting. Ms. Garcia reported a history of migraine headaches but was not taking medication. She was given a prescription for Vicodin 5 mg. Lab results also showed elevated glucose at 133. A CT scan of the brain without contrast was read as unremarkable for acute neuropathology.

Ms. Garcia underwent polysomnography on March 13, 2009. Data generated from the study was described as consistent with mild obstructive sleep apnea, although it was thought that degree of sleep apnea could be underestimated because no supine data was obtained.

During a surgical procedure to remove gallstones, on March 2 2010, Dr. McCann noted that Ms. Garcia had diffuse, moderate "fatty liver disease."

An examination of December 21 2011 by Dr. Zygmunt at the Elmhurst Pain Clinic noted that Ms. Garcia "has no symptoms of depression. She said she had a psychological evaluation but considering the number of symptoms and discomfort that she has, it would not be surprising if she did."

A diagnosis of fibromyalgia was made again on April 21, 2011 with Ms. Garcia describing significant stress as a result of losing her home and living out of boxes. She has aches and pain that are significant from lifting and packing. Adderall helped concentration and fatigue but improvement was temporary.

An April 20 2011 MRI of the brain with and without contrast was reviewed by radiologist Joseph Carabetta MD. Ms. Garcia was 43 at the time and was referred for severe left sided headaches, memory loss and a history of fibromyalgia. Cerebral findings included several "scattered bilateral frontal, left parietal and bilateral occipital foci of abnormal FLAIR signal hyperintensity, each about 2 mm diameter" that were stable compared with a 2/13/09 examination and which the radiologist opined were nonspecific, within normal limits for Ms. Garcia's age and "probably of no current clinical significance." No other abnormality was described in the cerebrum, cerebellum or brainstem.

A County Care clinical note from Crystal Roman RMA to Dr. Norberg on November 13 2014 described that Ms. Garcia was requesting Adderall for attention deficit and that she has been without it since October.

> "She was also very upset because she said that she has been diagnosed with an "attention problem" by you for which you are sending her to psychiatry. Patient said that she clearly had informed you that she does not have ADD and that she was getting the Adderall from Rush Rheumatology for fibromyalgia."

A December 9 2015 clinical note from Dr. Pillai described Ms. Garcia as having been prescribed CPAP for sleep apnea, but that she discontinued it "after a short period of use."

Diagnoses, per Dr. Pillai, as of June 1, 2021, included diabetes, anxiety, depression, osteoarthritis, hypothyroidism and vitamin D deficiency. Ms. Garcia also has diabetes mellitus that is insulin-dependent as well as essential hypertension and inflammatory bowel disease. Psychoactive medications taken and prescribed at that time included amphetamine-dextroamphetamine (Adderall), Alprazolam, Butalbital-APAP-caffeine (Fioricet) and hydrocodone-acetaminophen.

A June 2 2021 progress note from Dr. Pillai included a diagnosis of anxiety state with insomnia and that Ms. Garcia had not been taking her clonazepam. She was to restart on clonazepam .5 mg once daily and take Xanax/alprazolam only if necessary for breakthrough anxiety. Ms. Garcia was diagnosed with inflammatory bowel disease, recurrent episodes of abdominal pain, diarrhea with blood, and black stools. CT scan in the emergency room noted inflamed bowel wall.

Elmhurst pathology lab results on June 28 2021 summarized Dr. Pillai's diagnoses, which included:

> "Left-sided weakness 5/28/2020 by Belmont, Daniel, MD; Polyarthralgia 8/4/2020 by Pillai, Anita, MD; Attention deficit disorder (ADD) without hyperactivity 8/4/2020 by Pillai, Anita, MD; Telogen effluvium 8/4/2020 by Pillai, Anita, MD; Cystitis 8/27/2020 by Pillai, Anita, MD; Medial epicondylitis of elbow, right 9/25/2020 by Pillai, Anita, MD; Pancolitis (HCC) 4/9/2021 by Pillai, Anita, MD; Meralgia paresthetica 4/9/2021 by Pillai, Anita, MD 4/9/2021 by Pillai, Anita, MD; Notalgia paresthetica 4/9/2021 by Pillai, Anita, MD; Inflammatory bowel disease 6/1/2021 by Pillai, Anita, MD; Post-COVID-19 syndrome manifesting as chronic concentration deficit 9/16/2021 by Pillai, Anita, MD; DOE (dyspnea on exertion) 10/14/2021 by Pillai, Anita, MD; Left upper quadrant abdominal pain 10/14/2021 by Pillai, Anita, MD; PMR (polymyalgia rheumatica) (HCC) 12/2/2021 by Pillai, Anita, MD; POTS (postural orthostatic tachycardia syndrome) 12/2/2021 by Pillai, Anita, MD; Cognitive change"

A December 8 2021 clinical note from Mariam Khan described that Ms. Garcia has a history of Hypertension, Diabetes Mellitus, Hypothyroid and Anxiety/Depression. Fibromyalgia presented with generalized pain for many years

> "but over the past 2 months it has worsened. She has pain in her neck, mid back, shoulders, elbows, L hip, bilateral knees (L worse than R). She did have COVID in May 2020. States that her symptoms have worsened since then. She has been on multiple medications in the past, most recently gabapentin and Cymbalta but both had side effects and did not work therefore she discontinued it. She also has a lot of muscle pain throughout her body. She is unable to abduct her left shoulder due to pain. She also is unable to lay on her left side due to her left hip pain. She was recently started on Norco last week, helps her pain slightly. Also taking Tylenol arthritis, meloxicam and tizanidine."

A January 4 2022 brain MRI signed by Dr. Khan concluded: "1. Multiple small white matter signal foci bilateral cerebral hemispheres most likely chronic white matter microvascular ischemic changes versus chronic post headache sequela without significant change. 2. No restricted diffusion or acute infarction. 3. No abnormal intracranial enhancement. 4. Small

benign pineal region cyst redemonstrated."

Ms. Garcia was described as

> a 54 year old woman with past medical history of migraines with Fioricet PRN, COVID in the past, diabetes, hypothyroidism, fibromyalgia, PMR, TMJ with Clonazepam nightly, hypertension, presents with facial paresthesias and brain fog since COVID vaccine 10/18/2021. She has suffered significant loss of functioning, leading to significant distress. Her neurological examination is significant for nonphysiological findings (vibratory splitting in V1 bilaterally) and left hemisensory loss including face without culprit lesion on MRI. Is also significantly tearful throughout the interview, concerning that there is a component of anxiety and depression contributing to her symptoms."

MRI findings were considered to represent small white matter foci bilaterally that were likely chronic microvascular ischemic changes versus migraine related. There were no acute findings, and there was a benign pineal cyst. Ms. Garcia's symptoms were considered

> "likely multifactorial, related to worsening COVID related brain fog and fibromyalgia but she warrants secondary metabolic evaluation such as B12 deficiency and subclinical seizures with EEG. She is worried that her symptoms are all related to the COVID vaccine; I reassured her that we do not yet know that as we are still doing work up; what is also worrisome is that she is at risk for COVID re-infection and potential worsening of these symptoms from that or provocation of new COVID related complications."

A progress note of January 24, 2022 noted that chronic hypertension is gradually improving with medication. Other symptoms include anxiety, chest pain, malaise. Ms. Garcia reported concentration, attention and focus deficits, diagnosed by Dr. Pillai as related to Post-COVID syndrome.

Ms. Garcia had been employed at Alivio Medical Center from 2003-2021, but reported in her deposition that she had to quit in 2012, due to declines in health. She now works as an independent contractor for Seminario Biblico Hispano. She reports having a bachelor's degree in psychology and theology, and a masters in human services and executive leadership from Loyola University.

In her deposition, Ms. Garcia described having had severe migraines while working at Alivio. She noted that her work included constant traveling for conferences and public speaking and that it became difficult for her to keep up with everything. She suggested that her first bad migraine occurred around 2008, 2009 or 2010, and that, coupled with pain, she became afraid of traveling to conferences. In her son Byron's deposition, he described Ms. Garcia's work at Alivio as highly stressful and that work stress was wearing her down and contributing to her depression.

CLINICAL INTERVIEW

Ms. Garcia is a Spanish-language speaking female of average height and heavyset build. She arrived on time for the evaluation, accompanied by her husband, Eduardo, for an examination day in which both she and Mr. Garcia had agreed to be alternately interviewed and complete various tests or other procedures, as negotiated between defense counsel and their own attorney. She and her husband were made aware of my status as an examiner and were aware that reports from their interview and test results would be made available to defense and plaintiff counsel. Ms. Garcia's interview was conducted while Mr. Garcia completed questionnaires in an adjoining room. When she was not being interviewed, Ms. Garcia completed English-language versions of various psychological self-report measures.

When asked to describe her most salient problems, Ms. Garcia indicated that they are related to "the things we are going through with the bank." She reported that she has struggled with pain every day for many years "all over my body" which was diagnosed as fibromyalgia. Pain is especially severe in "my neck and my shoulders, most of the times and days and stress makes it worse. It's there with or without the stress, but stress makes it worse."

I asked Ms. Garcia about the development of her symptoms and she indicated that her migraine headache began in the 1990s and she received a diagnosis of fibromyalgia around 2005. She recalls that even at a young age

> "I remember I got a late menstrual period and I started having very bad headache. Since I was growing up, they got worse and worse and became a type of migraine. When I got married and pregnant I had really bad headaches."

Ms. Garcia suggested that around the year 2000, her migraines disappeared but returned again around 2008 when "we started battling and struggled to keep our house." She suggested that her fibromyalgia began around 2005, but did not become unmanageable until her struggles to keep her house and mortgage. "Before, I was kind of dealing okay with it."

At some point, Ms. Garcia recalled undergoing a hysterectomy that caused some of her "hormone-related symptoms" to "settle down" and migraines to diminish in severity. She has tried a variety of medications over time, with limited success. In the past she has used Imitrex and Trazodone. She did not tolerate the latter, which caused late night oversedation where she would "wake up and hit my head on the wall." Ms. Garcia currently takes Butalbital which "sometimes helps", every four hours. She also puts " a lot of ice on my head and I close the windows" until the headache subsides. Headaches are said to last up to two days.

Ms. Garcia described that when she is not taking butalbital for headache, she alternates it with hydrocodone for chronic whole body pain. Both medications are prescribed by her primary care provider, Dr. Anita Pillai. Hydrocodone "gives me some relief for some hours but a lot of factors make it worse including the weather and activity." Ms. Garcia gives an example of going to Costco and having protracted pain after lifting boxes. She reports that her family is aware of this outcome and

> "my husband and my daughter yell 'stop don't lift!' And my husband, who also suffers from back pain, says 'next day, you will not get up from bed!' But I want to help! I was trying to do some kind of activity. I even used to do power walks or Zumba but I haven't been able to lately because of pain."

At present, Ms. Garcia asserted that she is unable to work, due to pain and other health problems. In the past, she characterized herself as having been a very effective and productive manager of 20 employees.

> "I developed the curriculum for children to teach other children how to prevent diabetes and obesity. I believe we received some funding from Nickelodeon and Men's Health and Comcast and Avon. We began the program with $12,000 and when I left the program, we had close to 3 million! I went to the Director and said 'I want to get a grant for $1 million" and the Director said 'are you crazy? ' But I said, 'I know we can get a grant, not only for diabetes prevention for diabetes control! And here it came! $2 million! We got that money in 2011."

Ms. Garcia dates deterioration in her health to about 2008-2009 when she and her husband were struggling to make mortgage payments. She alleges that their bank encouraged the family to refinance their loan with a mortgage or interest rate that apparently ballooned to an unaffordable amount and that as result, her husband could no longer afford the monthly payments. Due to "a dip in the economy" Ms. Garcia indicated that

> "it was a hard time for my husband. With the economy, nobody would call him. Everybody was doing remodeling by themselves. He was earning some money here and there, but his work and my salary didn't cover what the bank wanted. The last proposal they made was almost $2000. Our payments had started at $1200. We had recently refinanced and they told us that 'maybe the interest would change, but in two years you can do it again you can lower your payment'".

Ms. Garcia stated that her family

> "wanted the bank to give us a loan that we could afford. It was very intense because it was more than a year back and forth with the bank; by phone, by fax, by letter, sending and sending documents but we would never speak to anyone on the phone. My health got really bad then."

Ms. Garcia recalled getting a series of epidural injections around 2009-2010 "during the time we were struggling with this" but these would give her relief for only 2-4 months. "It worked sometimes and sometimes they didn't." She was also sent to a pain clinic "but I never wanted to use those drugs." Throughout this time, Ms. Garcia reports attempting to negotiate with the bank and that she tried to keep working but that her health deteriorated to the point that she quit in 2012.

> "We were strongly trying to keep our home, because my daughter has special needs and we wanted to live there because of the schools. We were happy fixing the house, even though it was the ugliest. I remember my son saying 'why do I live in the ugliest house? ' We worked very hard to fix everything inside and it wasn't the nicest, but one of the nicest, at least on that street. I was so tired of dealing with the bank and

> in distress and one day they said "you failed to send the documents we asked you to." I said 'we sent the documents!" The next day, we got a letter saying the house wasn't ours because they sold it at an auction. I was continuing to work because I love my job and this was my home. They sold the house in 2011. I wanted to continue to work because I wanted to oversee the money they got in the program and hire people in the program but I couldn't anymore because my health and my emotions were worse and it was a lot; we had to get out of the house so fast. We had to sell things. I finally stopped working in 2012."

Ms. Garcia still wishes to return to productive employment but states she is afraid of being unable to perform at her past level of productivity. She reports that her symptoms leave her depressed and unmotivated; that "when I go through these episodes of really bad pain or days of migraine, I feel so low and so depressed." Ms. Garcia denied ever having suicidal thoughts. She stated, "I believe my faith plays a role in how I'm able to tolerate pain and my health. But what I really want to do is be productive."

Ms. Garcia reports that her last visit with her primary care physician was about two months ago where her thyroid levels were within normal range and her diabetes has been "very well controlled." She is currently of obese stature at 5'2" and an estimated weight of 196 pounds but she is not on any supervised nutritional or weight loss program.

Sleep described as poor, at about four or five hours a night and interrupted by pain. Ms. Garcia reports that she snores, was diagnosed with obstructive sleep apnea and prescribed a CPAP machine

> "but they took it away from me. I made a mistake when I went to see my sister in California and they gave me the machine but I didn't take it with me because it would make my luggage too heavy. When I came back, they said 'we want to pick up the machine because you didn't use it for two weeks.' I didn't know that I needed to use it then."

Ms. Garcia reports that she cannot obtain a new CPAP machine without a follow-up sleep study but she has not scheduled it.

Ms. Garcia described her Fibromyalgia symptoms as worsening, despite medication, and that the diagnosis of fibromyalgia was confirmed by a Dr. Robert Katz at Rush Presbyterian St. Luke's Hospital. She has been given many medications, but had no sustained success. She was tried on the antidepressant Cymbalta "which made me want to cry" and other pain medications, but all produced intolerable side effects.

I asked Ms. Garcia whether she now considered herself depressed. She replied that she had discussed this issue with her primary care physician, and had insisted that she did not wish this diagnosis to be placed on her record due to its connotation of moral weakness. Ms. Garcia denied ever having been referred to a psychiatrist for evaluation of mood symptoms. She denied ever being referred for cognitive behavior therapy (CBT) pain treatment, exercise or any nondrug treatment for either headache or fibromyalgia.

BEHAVIORAL OBSERVATIONS AND MENTAL STATUS: Ms. Garcia arrived per her scheduled time, accompanied by her husband Eduardo. She is an obese Hispanic female who appeared to be her stated age. She was oriented to time, place, person and situation. Sensorium was clear. There were no indications of visual or auditory hallucinations, delusions, or other psychotic process. Ms. Garcia denied current or past suicidal thoughts or plans and denied homicidal ideation. Mood swings were denied. Facial expression appeared depressed and angry when discussing her chronic pain history and her contention that the family home was sold at auction despite attempts to negotiate a workable payment plan. Ms. Garcia was otherwise friendly and normally interactive with this examiner through a day-long assessment when she and her husband were interviewed and examined alternately. When asked her preference for test materials to be in English or Spanish, Ms. Garcia requested English language questionnaires, indicating that English is her preferred reading language.

There were no observed attentional difficulties while working on test materials or being interviewed. Speech was normal in volume, rate, and timbre and clearly spoken with a Spanish inflected accident. There were no indications of pressure, aphasia or dysarthria.

Thought processes were goal-directed, linear and coherent with no indication of thought disorder. Use of vocabulary was considered to be appropriate to Ms. Garcia's level of education.

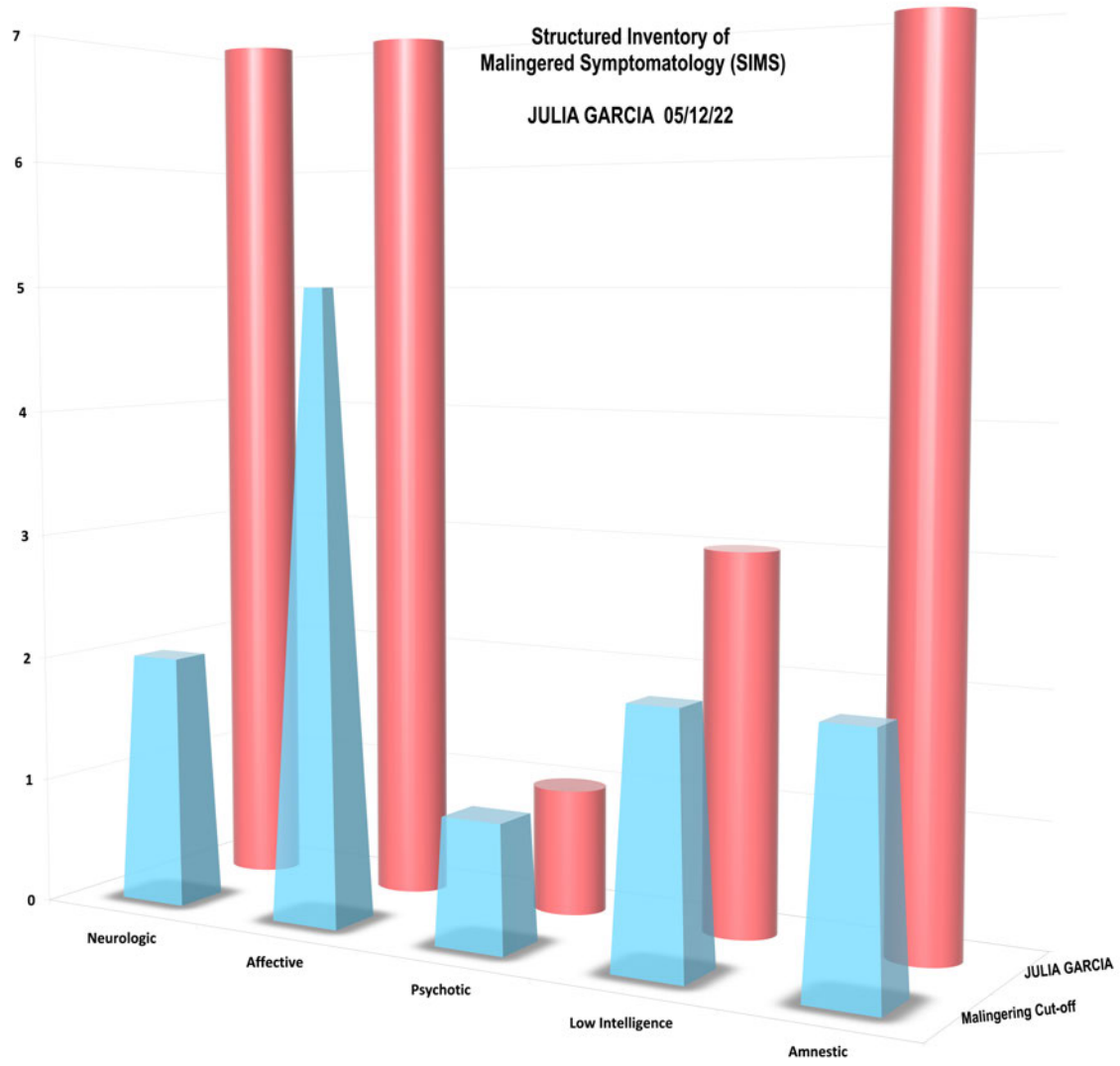
Gait appeared normal and not antalgic but Ms. Garcia reported daily chronic headache and whole body pain that she medicates every day with either a barbiturate (Butalbital) or an opioid (hydrocodone). Fine motor control and coordination appeared to be intact. Posture was normal. Grooming and hygiene were good.

Ms. Garcia was nominally cooperative in that she did not refuse any tests or questions. Her pattern of objective test results, however, was frequently exaggerated (see *Effort and Motivation* section, below) indicating that Ms. Garcia is not a consistently reliable historian of her symptoms and their attribution.

EFFORT, MOTIVATION AND VALIDITY: Ms. Garcia showed variable results on tests that screen for symptom plausibility and exaggeration. She did not attempt to exaggerate on a test that is sensitive to cognitive performance exaggeration (WMT) but demonstrated possibly exaggerated cognitive deficit on a test of executive function (WCST). She did not exaggerate on one symptom endorsement questionnaire (IOP-29) and one personality inventory (PAI) which were answered without elevated validity scales. However, three other objective symptom and personality inventories (SIMS; MMPI-3; BHI-2) did show evidence of symptom magnification. Ms. Garcia's overall test performance would suggest significant caution about reflexively assuming that her symptoms and their causes are accurately described; her self-reporting appears to be non-credible as often as credible.

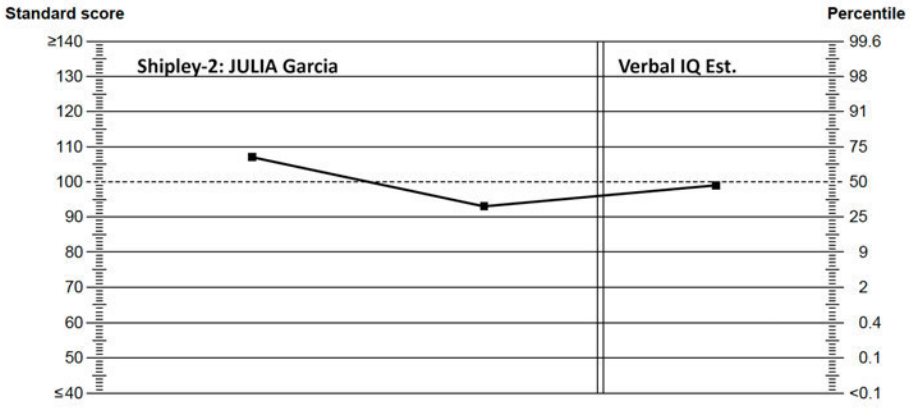
For example, Ms. Garcia was given a self-report problem questionnaire that is sensitive to unrealistic exaggeration and malingering. *The Structured Inventory of Malingered Symptomatology* (SIMS) yields a summary score of general feigning (Total score), and five nonoverlapping scales of more commonly feigned or exaggerated disorders: (a) Psychosis, (b) Neurologic Impairment, (c) Amnestic Disorders, (d) Low Intelligence, and (e) Affective

Disorders. It is self-report with a fifth grade reading level. Ms. Garcia performed well into the range of exaggerated symptom endorsement on scales related to neurologic, depression/anxiety and memory-related symptoms, above the exaggeration cutoff on symptoms related to intellectual impairment, and equal to the cutoff on the scale related to psychosis complaint. Her Total score (25) was almost *twice* the general test cutoff to be considered exaggerated. Results indicate that Ms. Garcia is admitting to rare, bizarre or implausible symptoms that are unlikely to be reported by credible patients, and which are likely to represent a magnified portrayal of her difficulties (see graph).

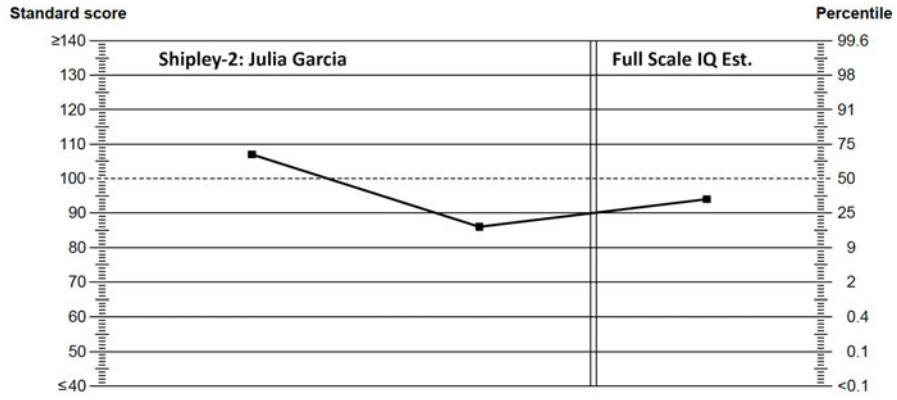


GENERAL COGNITIVE FUNCTIONS: On a screening test of intellectual function that does not contain validity measures (Shipley-2), Ms. Garcia scored in the Average range overall, with low average visuospatial abilities and average verbal skills (see graphs). Scores may be unremarkable for a bilingual individual with Ms. Garcia's educational and occupational attainments but may also represent a mild decline, considering that she reports having a Master's Degree. The Shipley-2 does not have built-in validity assessment.

Ms. Garcia was also administered the *Wisconsin Card Sorting Test (*WCST), a measure of perseveration and abstract concept formation. The patient is asked to sort cards into various categories but is not told the sorting strategy and must learn from feedback about whether each successive answer is correct or incorrect. Ms. Garcia performed in a mildly perseverative range, but her answer pattern raised suspicion about exaggeration. She scored above the malingering cutoff for an embedded validity measure on this test[1]. If Ms. Garcia's response profile on the WCST is not exaggerated, it would suggest mild problems with cognitive flexibility, problem-solving and freedom from impulsive responding.



	Vocabulary	Abstraction	Composite A
Standard score	**107**	**93**	**99**
Percentile rank	68	32	47
Raw score	34	12	
Interpretive Category	Average	Average	Average



	Vocabulary	Block Patterns	Composite B
Standard score	**107**	**86**	**94**
Percentile rank	68	18	34
Raw score	34	8	
Interpretive Category	Average	Below Average	Average

[1] Sweet, J., and Nelson, N. W. (2007). Validity indicators within executive function measures. In K. Boone (Ed.) *Assessment of Feigned Cognitive Impairment,* New York: The Guilford Press, p. 152-177.

PERSONALITY TEST RESULTS: On the newest version of the most widely used adult objective personality inventory (MMPI-3), Ms. Garcia produced an elevated score (t89) on the FBS scale, which is one of the best validated MMPI scales for detection of somatic malingering[2] and overreported clinical symptom reporting in forensic groups.[3] She also produced an elevated score on the RBS scale (t84), which is highly sensitive to exaggerated claims of cognitive impairment among individuals seeking disability.[4] There were no indications of minimization or underreporting. Ms. Garcia's clinical endorsement levels on other MMPI-3 scales, especially in physical and cognitive domains, are understood to be potentially tainted by exaggeration. She may magnify these symptoms for secondary gain. She is endorsing high levels of diffuse physical complaints, probably involving a number of physical domains, e.g. neurologic, headache and GI.

Such individuals tend to be preoccupied with health issues and assert that physical problems interfere with their lives. They may show features of a somatic symptom disorder. Symptoms suggest vague neurologic complaints, generalized malaise and complaints of ill-health and feeling tired, weak or incapacitated. Internalizing symptoms may include feelings of self-doubt, futility, low self-confidence (SFD=t72). Ms. Garcia's level of perceived stress is somewhat above average (STR=t68). Her level of endorsed anxiety is borderline elevated (ARX=t66). She is also reporting elevated levels of introversion, pessimism and lack of positive experiences (INTR=t69). Ms. Garcia is not reporting significant levels of thought disorder or behavioral acting out. Scales related to interpersonal competence are within the normal range.

On the *Personality Assessment Inventory* (PAI) which also comprehensively examines symptom and personality patterns, Ms. Garcia did not attempt to exaggerate her symptoms, but tended to described herself as being relatively free of common shortcomings and somewhat reluctant to acknowledge normal, minor faults. While she did not appear to intentionally distort her profile, she may underreport significant findings in certain areas.

Ms. Garcia's clinical symptom endorsement profile on the PAI was remarkable for a combination of extreme concern about physical symptoms and clinical depression. Her physical symptom focus is unusual, even in clinical samples, and her PAI score describes someone who is ruminatively preoccupied with physical functioning, health matters and a perception of being severely impaired from physical symptoms. Somatic complaints are likely to be chronic and accompanied by fatigue, weakness and claimed inability to perform even minimal role expectations.

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[2] Granacher, R. P., and Berry, D. T. R. (2008). Feigned medical presentations. In R. Rogers (Ed.). p. 145-156. *Clinical Assessment of Malingering and Deception.* New York: The Guilford Press.

[3] Dustin B Wygant, D. B., Ben-Porath, Y. S. Arbisi, P. A. *et al.* (2009). Examination of the MMPI-2 restructured form (MMPI-2-RF) validity scales in civil forensic settings: findings from simulation and known group samples. *Archives of Clinical Neuropsychology, 24,* 671-680.

[4] Tylicki, J. L., Rai, J. K., Arends, P., et al. (2020). A comparison of the MMPI-2-RF and PAI overreporting indicators in a civil forensic sample with emphasis on the Response Bias Scale (RBS) and the Cognitive Bias Scale (CBS). *Psychological Assessment, doi: 10.1037/pas0000968. Online ahead of print.*

Per PAI results, Ms. Garcia is likely to report that her daily functioning is compromised by numerous, complex and varied physical problems that are difficult to treat successfully. Her complaints are likely to include symptoms of distress in several biological systems, including neurological, gastrointestinal, and musculoskeletal and her extreme endorsement pattern. In the absence of objective medical disease state, this pattern is consistent with expression of psychological symptoms as a "Conversion" and/or "Somatic Symptom" disorder. "Conversion disorder" is generally understood to include motor or sensory function deficits which mimic neurologic or medical conditions but which are not clinically compatible with such conditions. "Somatic symptom disorder" is defined as having one or more distressing or disruptive physical symptoms, including (per DSM-5) excessive thoughts, feelings, or behaviors related to those physical symptoms, persistently high anxiety about health or symptoms, and excessive focus on those symptoms or health concerns.

Ms. Garcia's PAI profile included significant depressive symptoms, with likely thoughts of worthlessness, hopelessness, and personal failure. She admits openly to feelings of sadness, a loss of interest in normal activities, and a loss of pleasure for things that were previously enjoyed. She endorsed a fixed, rather negative self-evaluation and is likely to be self-critical, and focus upon past failures and lost opportunities. She may dismiss her good accomplishments as due to luck or someone else's actions. Ms. Garcia is likely to show disturbed sleep pattern, decreased energy and sexual interest and a loss of appetite. Psychomotor slowing might also be expected.

In contrast, PAI scales related to anxiety, stress, worry and sensitivity were within a normal range, although Ms. Garcia may occasionally experience, mild maladaptive behavior patterns aimed at controlling anxiety. She does report having experienced a disturbing traumatic event in the past that continues to distress her and produce recurrent anxiety.

Despite her symptoms, Ms. Garcia describes herself as being warm, friendly, and sympathetic; she particularly values harmonious relationships and derives much satisfaction from these relationships. As a result, Ms. Garcia is likely to be uncomfortable with interpersonal confrontation or conflict and will tend to avoid controversy.

Ms. Garcia reports a current stress level comparable to normal adults, and having a large number of individuals to whom she can turn for support when needed.

On the PAI, Ms. Garcia denied problems with unusual thoughts, peculiar experiences, antisocial behaviors, loss of empathy, paranoia, extreme moodiness, impulsivity or unusually elevated mood.

PAI results suggests that Ms. Garcia tends to be satisfied with herself as she is, and is not experiencing marked distress. As a result, she sees little need for changes in her behavior and she may be somewhat defensive, reluctant to discuss personal problems and terminate psychotherapy early.

Ms. Garcia was also given a test that examines patterns of symptom production and possible biopsychosocial difficulties in medical patients (BHI-2). Her validity profile on this measure

was remarkable for portraying her life as so terrible and negative that only the *most extreme 20 percent of patients who are asked to fake* bad would produce similar profiles. Patients who produce similar profiles are attempting to impress the examiner how bad their symptoms are. In the context of other exaggerated measures, the validity profile is consistent with exaggeration in the context of litigation to strengthen her case.

Ms. Garcia's BHI-2 symptom magnification is likely reflected in a remarkably high number of symptom endorsements related to disabling illness and pain symptoms. These are compounded by psychophysical reactivity. Her report of pain symptoms was higher than seen in 97% of patients. Ms. Garcia endorsed 22 of the 26 Somatic Complaints items and reported pain in 9 of the 10 body areas on the Pain Complaints scale. She also reported extreme peak pain (Peak Pain 10/10) that she characterized as disabling and intolerable. She reported that even her mildest pain in the last month was intolerable and disabling.

Ms. Garcia described dysfunction in multiple organ systems on the BHI-2. In the absence of obvious severe physical damage and objective medical injury or disease, this broad and extreme pattern of complaint is associated with somatization, somatic preoccupation and reacting with extreme physical symptoms when stressed. Ms. Garcia may consider her physical problems to be a central, defining feature of her self-concept, and that being disabled is a core feature of her identity. Such perceptions are limiting and self-defeating. Patients who incorrectly assume they are disabled or incapable are less likely to try.

Other motivations to claim disability are suggested by BHI-2 patterns, including *primary gain* (e.g., the intrinsic appeal of being a patient) or *secondary gain* (e.g., financial compensation and/or work avoidance). Overall, Ms. Garcia's BHI-2 profile strongly indicates that physical symptom treatment will not lead to improvement because the primary bases for her extreme symptom complaints (outside of medication-related issues which are discussed later in this report) appear to be motivational and psychological, rather than physical.

While Ms. Garcia acknowledged having some emotional distress on the BHI-2, her profile, corroborated by interview, indicated that she views emotional problems as moral weakness. Such individuals tend to deny having a psychological basis for their psychological problems and may not be aware of, or unwilling to admit, that physical symptoms have an emotional basis. As a result they are unlikely to develop effective coping strategies other than physical symptom claims.

Ms. Garcia also reported a severe level of depressive thoughts and feelings on the BHI-2. Her self-ratings were higher than seen in 95% of credible patients. Without an objectively severe medical condition, these symptoms are better explained by personality traits and their interaction with environmental conditions.

Ms. Garcia reports that her depression is accompanied by passive "wishing I was dead at times" thoughts, although she denied active suicidal ideation, intent or plans in clinical interview. Because she is undergoing a forensic psychological IME, the possibility of exaggerated depression must be considered and that she may be attempting to portray her situation and symptoms in the worst possible light.

To the extent that Ms. Garcia has credible emotional symptoms underneath a magnified presentation, she is asserting feelings of loss, helplessness, vegetative depression and autonomic anxiety. She described unusually high levels of reactive tension characterized by muscular tightness, which would increase perceived pain and further erode her capacity to cope with general life exigencies.

Ms. Garcia's BHI-2 profile was also remarkable for very high levels of what is termed *Symptom Dependency;* higher than 86 percent of patients. Symptom dependency is the tendency to use symptom complaints to manipulate attachments and attention from others. This is a long-term personality pattern that typically begins in childhood where individuals believe they are entitled to support when they suffer from physical infirmity. People vary in their demand for such support, and in some cases, come to believe they are entitled to extraordinary support by asserting their maladies are so severe they cannot be expected to cope on their own. Ms. Garcia reports symptoms associated with life stressors that are unresponsive to treatment and which require others to provide support. Patients with Ms. Garcia's level of symptom dependency use symptoms to seek support from others and assert that others are insensitive if they do not offer help. They may be manipulative and use their symptoms for secondary gain.

An additional risk factor reported on the BHI-2 is Ms. Garcia's belief that she deserves financial compensation for her pain and suffering. This could negatively affect her motivation to admit symptom improvement, since admission of improvement would subvert the possibility of secondary gain. Ms. Garcia also described that when she worked, she was dissatisfied with her job.

On the BHI-2, Ms. Garcia denied problems with angry and aggressive feelings. She denied history of physical or sexual assault.

CONCLUSIONS

Ms. Garcia is a 54 year old female who is being seen in the context of litigation in the matter described above. She and her husband were examined in a context agreed upon by their attorney and the defense firm. The evaluation proceeded without incident and both Ms. and Mr. Garcia expressed understanding of my role as an examiner in their case, where both defense and plaintiff law firms would have access to my report, based on my review and results from their examinations.

Based on my examination and extensive review, to a reasonable standard of neuropsychological certainty, Ms. Garcia has multiple pre-existing medical problems, mismanaged medications and an ineffective, iatrogenic treatment strategy. These would predictably predispose her to chronic psychological problems, poor stress tolerance, and perception of chronic ill-being. Rather than being specific to a bank foreclosure, or permanently changed by the foreclosure, Ms. Garcia's symptoms developed before her financial difficulties, have fluctuated over time, and are associated with medical conditions of record, including diabetes, sleep apnea, fibromyalgia/chronic pain, small vessel disease and polypharmacy.

Symptoms are reactive to stress as a general personality pattern, rather than a unique response to the home foreclosure. Ms. Garcia was observably depressed during the evaluation. She attributes that depression to her bank foreclosure, however she and her son have also suggested that headaches, pain and work stress predated her mortgage-related difficulties. Her history is also positive for medical conditions unrelated to her financial difficulties but which are associated with depression.

For example, patients with diabetes show twice the rate of depression as the general population. While depression is considered "an understandable reaction to the diagnosis of a chronic physical illness" patients with diabetes also suffer neurologic and neuropsychological damage from diabetes that contribute to depression. Inactivity, poor diet and poor self-care management worsen glycemic control and further worsen depressive symptoms in a vicious cycle.[5]

Ms. Garcia's diabetes, along with elevated body mass are well known risk factors for higher dementia risk[6] and cerebrovascular disease. There are small-to-moderate neuropsychological effects of diabetes on motor function, executive function, processing speed, verbal memory and visual memory.[7] Diabetes and it's progressive effect on neurovascular function would be a predictable contributing cause of any credible perception of cognitive inefficiency.

Ms. Garcia also reported that she had been diagnosed with obstructive sleep apnea (OSA) in the past, but that her CPAP machine was taken away for supposed non-compliance when she went to visit relatives in another State. She reports not taking her machine along, for fear of being charged for overweight luggage. I have no records that address this contention, but Ms. Garcia requires re-examination and a current sleep study to determine if she continues to have OSA. In OSA, the individual's airway narrows or becomes blocked multiple times each night. Ensuing loss of oxygen contributes to breaking down the blood-brain and leads to high blood pressure, depression, memory loss and anxiety. OSA can cause extreme daytime sleepiness and can lead to stroke, diabetes and other severe consequences.

Patients with obstructive sleep apnea suffer from both neuropsychological and psychological problems stemming from this disorder. From a neuropsychological perspective, such patients

> "show neuropsychological impairments ranging from vigilance decrements, attentional lapses and memory gaps to decreased motor coordination and there may be decreased brain metabolism and "gray matter loss in the frontal and temporo–

[5] Holt, R. (2019) Diabetes in psychiatric disease. *Medicine, 47,* 123-126.

[6] Luchsinger, J.A. (2010). Diabetes, related conditions, and dementia. Journal of Neurological Science. 15, 299, 35-38.

[7] Palta, P., Schneider, A. L. C., *et al.* (2014). Magnitude of cognitive dysfunction in adults with Type 2 diabetes: A meta-analysis of six cognitive domains and the most frequently reported neuropsychological tests within domains. *Journal of the International Neuropsychological Society, 20,* 278-298.

> parieto–occipital cortices, the thalamus, hippocampal region, some basal ganglia and cerebellar regions, mainly in the right hemisphere."[8]

Sleep apnea may contribute to progression of white matter disease in the brain and may be a marker for subclinical cerebrovascular or cardiovascular disease.[9] Sleep apnea has a high incidence among patients with transient ischemic attack (TIA) and stroke[10] Daytime sleepiness or fatigue is a concomitant of sleep apnea and even mild sleep apnea may worsen depression and the quality of life.[11] Neuroanatomical regions and neuropsychological functions can be impaired as a consequence of sleep apnea, on a variety of cognitive tasks [12]

Untreated sleep apnea increases the risk for depression and anxiety; a recent review found about 1/3 of patients with obstructive sleep apnea also report depression and anxiety symptoms, and that frequently observed medical co-morbidities of apnea, including cardiovascular diseases or metabolic imbalance, could further contribute to elevated levels of mental distress.[13]

> Depression and anxiety are associated with OSA, but they are overlooked in common practice. Diagnosis and treatment of depression and anxiety in OSA patients has room for important improvement. A physician focusing on symptoms and treatment of the physical illness, to the exclusion of any associated mental illness, results in incomplete care of the patient. In a disease like OSA, which has such a high percentage of comorbidity of psychiatric disorders, this is unfortunate."[14]

Ms. Garcia reports longstanding whole body chronic pain that has been diagnosed as fibromyalgia, a pain disorder with no objective body system injury or abnormality. One of the developers of the term was Dr. Frederick Wolfe, who now regrets giving this symptom constellation a new label.

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[8] Yaoui, K., Bertran, F. *et al.* (2009). A combined neuropsychological and brain imaging study of obstructive sleep apnea. *Journal of Sleep Research, 18,* 36-48.

[9] Robbins, J., Redline, S., Ervin, A., Waisieben, J. A., Ding, J., and Nieto, F. J. (2005). Associations of sleep-disordered breathing and cerebral changes on MRI. *Journal of Clinical Sleep Medicine, April 15, 1,* (2), 159-165.

[10] Bassetti, C., and Aldrich, M.D. (1999). Sleep apnea in acute cerebrovascular diseases: final report on 128 patients. *Sleep, 22,* 217-223.

[11] Brown, W. D. (2005). The psychosocial aspects of obstructive sleep apnea. *Seminars in respiratory critical care medicine, 26,* 33-43.

[12] Zimmerman ME, Aloia MS. (2006). A review of neuroimaging in obstructive sleep apnea. *Journal of Clinical Sleep Medicine, 2,*461-471.

[13] Garbarino, S., Bardwell, W. A., Guglielmi, O., *et al.* (2020). Association of Anxiety and Depression in Obstructive Sleep Apnea Patients: A Systematic Review and Meta-Analysis, *Behavioral Sleep Medicine, 18,* 35-57

> "For a moment in time, we thought we had discovered a new physical disease," he said. "But it was the emperor's new clothes. When we started out, in the eighties, we saw patients going from doctor to doctor with pain. We believed that by telling them they had fibromyalgia we reduced stress and reduced medical utilization. . .My view now is that we are creating an illness rather than curing one."[15]

"Signs" of fibromyalgia, i.e., the number of tender points in patients with fibromyalgia "correlate most closely with their degree of unhappiness." [16] Ms. Garcia's complaint of generalized body pain

> "has been part of psychogenic illnesses such as hysteria and neurasthenia since ancient times, in modern times the symptom has become the foundation of a separate syndrome: fibromyalgia. Modern patients are less willing to accept a psychogenic explanation for their symptoms, and they want validation of their symptoms by having them attributed to an organic cause."[17]

Ms. Garcia's unsuccessful physical treatment of her fibromyalgia symptoms reflects that

> "most physicians are uncomfortable with a psychosomatic diagnosis and prefer to lump clinical symptoms into a specific disease category with an organic cause. . . The modern-day practice of medicine frequently consists of forming a long list of organic diseases and ordering tests to rule them in or out. This approach fails to work and doesn't work well with psychosomatic illness. It typically worsens the symptoms, like throwing fuel on the fire."[18]

Ms. Garcia's physical and medication treatments for fibromyalgia, instead of curing her symptoms, have increased her symptom focus and misattribution of those symptoms, as being diagnosed with fibromyalgia causes patients

> "to search for additional symptoms to corroborate the new diagnosis, leading to amplification of everyday nonspecific symptoms previously thought to be insignificant. This vicious cycle of symptom amplification further initiates fear and anxiety, which can trigger a range of somatic symptoms on its own. The result can be the development of a defined symptom complex such as fibromyalgia or chronic fatigue syndrome." [19]

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[15] Groopman, J. (2000). Hurting all over. *The New Yorker,* November 13, 78-92.

[16] Groopman, J. (2000). Hurting all over. *The New Yorker,* November 13, 78-92.

[17] Baloh, R. W. (2020) Medically Unexplained Symptoms Springer/Copernicus. doi.org/10.1007/978-3-030-59181-6.

[18] Baloh, R. W. (2020) Medically Unexplained Symptoms Springer/Copernicus. doi.org/10.1007/978-3-030-59181-6 .

[19] Baloh, R. W. (2020) Medically Unexplained Symptoms Springer/Copernicus. doi.org/10.1007/978-3-030-59181-6.

In 2022, Ms. Garcia's most recent brain MRI was reported to show cerebral ischemic brain lesions or "small vessel disease". MRI white matter signal abnormalities identified as small vessel ischemic disease reflect focal and diffuse lesions of the subcortical and periventricular white matter, as well as lacunes and microinfarcts of the central gray matter[20]. White matter abnormalities on MRI are associated with an increased risk of dementia and individuals with more severe white matter lesions have a twofold increased risk of dementia.[21] Small vessel disease is typically progressive and associated with cognitive decline.[22] especially if underlying causes (e.g., hypertension, hypercholesterolemia, sleep apnea, etc.) are not aggressively managed. Progressive cognitive impairments in various neuropsychological functions accompany developing small vessel disease.[23] Emotional and neuropsychiatric symptoms increase with progressive small vessel disease/cerebral ischemia[24] [25]. To the extent that Ms. Garcia perceives worsening overall cognitive and emotional functioning, progression of small vessel disease (which is unrelated to her financial history) is also a likely contributing cause.

Finally, to a reasonable standard of neuropsychological and psychopharmacological certainty, Ms. Garcia receives medications that individually, and in combination, are likely to extend and worsen her symptoms, and which have risks for potentially dangerous interactions. For example, her chronic headache is potentially worsened in length and degree by daily use of barbiturate and opioid medications. These medications are well known to produce *medication overuse headache* (MOH), a chronic form of migraine headache, where the medications themselves sustain headache symptoms.

> "MOH is headache occurring on 15 or more days per month developing as a consequence of regular overuse of acute or symptomatic headache medication (on 10 or more, or 15 or more days per month, depending on the medication) for more than 3 months. It usually, but not invariably, resolves after the overuse is stopped[26]

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[20] Udaka F. et al. (2002) White matter lesions and dementia: MRI-pathological correlation. *Annals of the New York Academy of Science, 977,* 411-415.

[21] Kuller, L.H. *et al.* (2005). Determinants of vascular dementia in the Cardiovascular Health Cognition Study. *Neurology 64*, 1548-1552

[22]Longstreth, W.T. Jr *et al.* (2005). Incidence, manifestations, and predictors of worsening white matter on serial cranial magnetic resonance imaging in the elderly: the Cardiovascular Health Study. *Stroke. 36*, 56-61;

[23]Prins, N.D. *et al.* (2005). Cerebral small-vessel disease and decline in information processing speed, executive function and memory. *Brain. 128*, 2034-2041

[24] Zhang AJ, Yu XJ, Wang M. (2010). The clinical manifestations and pathophysiology of cerebral small vessel disease. *Neuroscience Bulletin. 26*, 257-264.

[25] Clancy, U., Ramirez, J., Chappell, F. M. *et al.* (2022). Neuropsychiatric symptoms as a sign of small vessel disease progression in cognitive impairment *Cerebral Circulation – Cognition and Behavior, 3,* 1-8.

[26] Kristoffersen, E. S., and Lundqvist C. (2014). Medication-overuse headache: epidemiology, diagnosis and treatment. *Therapeutic Advances in Drug Safety, 5,* 87-99.

Medication Overuse Headache "is more likely to happen with butalbital and opioids than with migraine-specific drugs, as partial responses lead to recurrence, repeat dosing, and, eventually, overuse"[27] as defined above. Ms. Garcia's routine overuse of butalbital and opioids is also more likely to require inpatient detoxification to allow drug taper under observation and improve management of withdrawal symptoms.[28] Detoxification without analgesics or migraine medication is considered the most effective program to reduce MOH headache.[29]

Ms. Garcia's prognosis for headache and pain relief on her current treatment regimen is poor; her medication combination and frequency of use consistently predict poor prognosis, chronic headache at follow-up, increased headache days, and lower quality of life.[30] This suggests that, in addition to detoxification, non-drug treatments should be considered, e.g., cognitive behavioral pain treatment, biofeedback, behavior modification and/or treatment and/or medications that do not sustain MOH.

Severe concerns with chronic opioid prescription use are also evident. Chronic opioid use is controversial and problematic and as pain management strategy.

> "Opioids are used extensively despite a lack of evidence of their effectiveness in improving pain or functional status with potential side effects of hyperalgesia, negative hormonal and immune effects, addiction and abuse" [31]

A recent review concluded that in nonmalignant pain patients (e.g., Ms. Garcia), the theoretical benefit of prescribing opioids for

> "functional capacity and health-related quality of life still remain to be proven, [while] studies are emerging that describe serious long-term consequences such as

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[27] Tepper S. J., and Tepper, D. E. (2010). Breaking the cycle of medication overuse headache. *Cleveland Clinic Journal of Medicine, 77,* 236-244.

[28] Hans-Christoph Diener, H-C, Dodick, D., Evers, S. *et al.* (2019). Pathophysiology, prevention, and treatment of medication overuse headache. www.thelancet.com/neurology Published online June 4, 2019 http://dx.doi.org/10.1016/S1474-4422(19)30146-2 1.

[29] Carlsen, N. N., Munksgaard, S. B., Jensen, R. H., *et al.* (2017). Complete detoxification is the most effective treatment of medication-overuse headache: A randomized controlled open-label trial. *Cephalalgia, epub ahead of print.*

[30] Probyn, K., Bowers, H., Caldwell, F. *et al.* (2017). Prognostic factors for chronic headache. A systematic review. *Neurology, 89,* 291-301.

[31] Manchikanti, L. (2007). National drug control policy and prescription drug abuse: Facts and fallacies. *Pain Physician, 10,* 99-422.

> addiction, opioid-induced hyperalgesia, cognitive disorders, and suppression of the immune and reproductive systems.".[32]

A 2015 review concluded "there is no evidence that opioids improve return to work or reduce the use of other treatments. They may even limit the effectiveness of other treatments."[33]

Ms. Garcia's continuing complaints of extreme pain, to the degree they are not exaggerated, are a known consequence of chronic opioid administration. The phenomenon of *increased* pain from chronic opiate administration is termed *hyperalgesia*.

> "Hyperalgesia (also referred to as hyperalgia) is a relatively new recognized adverse effect, and is generally defined as an increased pain sensitivity. This sensitization presents as increasing pain despite increasing doses of opioids."[34]

Hyperalgesia combined with drug tolerance, addiction, sedation, depression, nausea and other side effects may be responsible for the poor outcome and loss of long-term efficacy of opioids to treat chronic pain.[35] The magnitude of pain relief from chronic opioid administration is only about 30%. Ms. Garcia's out-of-proportion pain complaints are likely enhanced by chronic narcotic administration, suggesting the need for detoxification.

> "With regard to chronic pain, it had long been known that some patients complained far out of proportion to objective findings. In the 1970s, multidisciplinary pain clinics were formed to address this problem, and they reported great success. They invariably detoxified patients who were opioid dependent, and it was these patients who were likely to be the successful cases."[36]

Psychopharmacologic additive effects from anxiolytics, e.g., clonazepam, which Ms. Garcia has also been prescribed, are also of concern.[37] There is an additive or even synergistic risk of respiratory depression, morbidity and acute death in combining opioids and anxiolytics[38]. Prescription polydrug dependence is highly likely. Neuropsychological side effects from this

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[32] Højsted J, Sjøgren P. (2007) An update on the role of opioids in the management of chronic pain of nonmalignant origin. *Current Opinions in Anaesthesiology*. 2*0,* 451-455.

[33] Deyo RA et al. Opioids for low back pain. (2015) *BMJ,* 5, 350.

[34] Benjamin, R., Trescot, A. M., *et al.* (2008). Opioid complications and side effects. *Pain Physician, 11, p.* S109.

[35] Deyo RA et al. Opioids for low back pain. (2015) *BMJ,* 5, 350.

[36] Streltzer, J., and Johansen, L. (2006) Prescription drug dependence and evolving beliefs about chronic pain management. *American Journal of Psychiatry, 163, 4, 594*-598.

[37] Deyo RA et al. Opioids for low back pain. (2015) *BMJ,* 5, 350.

[38] *First Do No Harm.* The Indiana Healthcare Providers Guide to the Safe, Effective Management of Chronic Non-Terminal Pain. www.in.gov/bitterpill/files/First_Do_No_Harm_V_1_0.pdf

combination of substances, to a reasonable standard of neuropsychological certainty, include depression, mood fluctuation, fatigue, cognitive inefficiency and memory problems.

Other drug interactions among Ms. Garcia's prescribed medications are potentially dangerous and problematic. For example, she takes Adderall (a stimulant) in combination with hydrocodone (a narcotic). Combined use of these medications places patients at risk for *serotonin syndrome*, a serious drug reaction in which too much of the neurotransmitter serotonin is produced. Symptoms may be life threatening and can include: confusion, agitation or restlessness, dilated pupils, headache, changes in blood pressure and/or temperature, nausea/vomiting, diarrhea, rapid heart rate, tremor, sweating and other symptoms including high fever and seizures. Clinically, being given an addictive sedative to counteract the effects of an addictive narcotic is counterproductive and indicates lack of prescription interaction oversight.

Ms. Garcia is also given a barbiturate (butalbital) that in combination with her anxiolytic (clonazepam) and narcotic (hydrocodone) interfere with attention, concentration, alertness and memory function. This drug combination also decreases clonazepam efficacy and increases risk of CNS and respiratory depression, psychomotor impairment and low blood pressure, with syncope.

Gabapentin and hydrocodone in combination risk CNS and respiratory depression and psychomotor impairment. Adding Adderall to Butalbital/caffeine risks severe vasoconstriction, arrythmia and hypertension. Ms. Garcia's medications include the potential for other drug interactions that interfere with thyroid hormone levels and antidiabetic agent efficacy.

Ms. Garcia's medication regimen is also peculiar for omission of formal psychiatric evaluation and treatment for obvious depressive symptoms. Instead, Ms. Garcia is being given narcotic, barbiturate and anxiolytic prescriptions that are likely to worsen her level of depression, combined with an amphetamine stimulant which can cause or increase anxiety and agitation.

Ms. Garcia informed me that she has attempted to prevent her primary care doctor from diagnosing (or presumably treating) depression; that she did not wish this diagnosis on record, viewing it as a moral weakness. Records indicate that psychiatric referral was considered for Ms. Garcia but not acted upon; this may represent unwillingness to comply on her part. Regardless, Ms. Garcia requires psychiatric management of mood symptoms, along with reconsideration of her pain treatment strategy *in toto.* She would benefit from aggressive, behavioral management of pain symptoms, and tapering/discontinuation of narcotics, benzodiazepines, barbiturates and amphetamines. This likely will require inpatient detoxification. Ms. Garcia's symptoms of headache and fibromyalgia are being made worse by chronic use of barbiturates and opioids. Ms. Garcia's current treatment regimen does not comply with best evidence recommendations for fibromyalgia treatment; these include supervised exercise program and focus on nonpharmacological therapies.

> "There should be a comprehensive assessment of pain, function and the psychosocial context. Management should take the form of a graduated approach with the aim of improving health-related quality of life. It should focus first on non-

> pharmacological modalities. This is based on availability, cost, safety issues and patient preference. . .***We were unanimous in providing a 'strong for' recommendation for the use of exercise, particularly given its effect on pain, physical function and well-being, availability, relatively low cost and lack of safety concerns .*** . . .There were some non-pharmacological therapies we did not recommend because of lack of effectiveness and/or low study quality: biofeedback, capsaicin, hypnotherapy, massage, SAMe and other complementary and alternative therapies. We provided a 'strong against' evaluation for chiropractic based on safety concerns. In case of lack of effect of the above therapeutic approaches, we recommend individualized therapy. . ***.CBT [cognitive behavior therapy] was effective at producing modest, long-term reductions in pain, disability and improving mood.*** Pharmacological therapies (all 'weak for') should be considered for those with severe pain (duloxetine, pregabalin, tramadol) or sleep disturbance (amitriptyline, cyclobenzaprine, pregabalin). Multimodal rehabilitation ('weak for') programmes should be considered for those with severe disability—in comparison to individual therapies, those that were multimodal improved a range of short-term outcomes. We did not recommend several pharmacological therapies including NSAIDs, MAOIs and SSRIs because of lack of efficacy and specifically ***gave a 'strong against' evaluation to growth hormone, sodium oxalate, strong opioids and corticosteroids based on lack of efficacy and high risk of side effects***[39]***"*** [bold italics mine]**.**

Ms. Garcia also requires aggressive management of small vessel disease by a cardiologist and neurologist and a repeat sleep study to determine if she requires CPAP.

Some of Ms. Garcia's more recent symptoms have been attributed to "Post-COVID" sequelae by her primary care physician. While this is possible, I consider this hypothesis to be speculative. Ms. Garcia's complex overlay of preexisting symptoms and medication interactions would make it impossible to differentiate additional subjective post-COVID complaints.

To summarize, Ms. Garcia has clinically diagnosable mood impairments and nonspecific subjective claims of ill-being that are predictable from long-standing, pre-claim medical and symptom history and from a combination of ineffective, inadequate and inappropriate treatment. Her mood symptoms are multifactorial, but are likely associated with chronic perception of physical ill-being from progressive disorders, reinforcement of psychosomatic pain symptoms by treaters, and polypharmacy causing drug dependence, medication overuse headache and hyperalgesia. She has a long history of headache, pain and other conditions that predate her current symptom display, and these symptoms fluctuate or worsen over time. She is reactive to any life or environmental stressors but her reactivity was a preexisting trait. Any worsening of medical or psychological symptoms after the time of her financial difficulties reflects a fluctuating and continuing pattern that began before her bank-related difficulties and continues afterward.

At the time of her home foreclosure, Ms. Garcia would understandably have become increasingly upset and depressed. At that time, she would have likely merited a diagnosis of

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[39] Macfarlane, G. J., Kronisch, C., Dean, L. E. *et al.* (2017). EULAR revised recommendations for the management of fibromyalgia. *Annals of the Rheumatic Diseases*, *76.* 318-328.

Adjustment Disorder with Depressed and Anxious features. This reflects a psychological reaction to an acutely difficult and stressful event. However, if Ms. Garcia specifically attributes ongoing and current symptoms to the foreclosure, such a claim would be best understood as due to litigation-based reinforcement, symptom misattribution, exaggeration and the fact that current litigation itself raises memories of this stressful event.

The current examination appears to be the first objective assessment of Ms. Garcia's psychological and neuropsychological symptoms and their validity. The only other reference to symptom validity testing by another doctor was a January 2022 note from Dr. Kahn, who indicated that Ms. Garcia produced several "non-physiological" symptoms, i.e., symptoms that were neurologically implausible. No other examiner reported using methodology to consider whether Ms. Garcia was exaggerating or producing clinically implausible symptoms.

In the current evaluation about half of Ms. Garcia's objective results were exaggerated; there is clearly a component of symptom magnification in her presentation. For this reason, more extensive neuropsychological assessment of Ms. Garcia's cognitive function would not have been possible; those data would have been contaminated by exaggeration.

To a reasonable standard of neuropsychological certainty, Ms. Garcia's combination of chronic medical conditions and psychopharmacological mismanagement suggest actual cognitive and emotional difficulties underneath her exaggerated presentation. Also to a reasonable standard of neuropsychological certainty, the exact pattern of pattern and degree of neuropsychological and psychological impairments is obscured by exaggeration. The complexity of Ms. Garcia's aggregate medical neuropsychological condition is such that "partitioning" which symptoms belong to which disorder is not possible.

In conclusion, Ms. Garcia's current presentation involves a mix of symptoms that are a combination of subjective ill-being from multiple medical disorders, mismanaged, iatrogenic polypharmacy and, per current objective neuropsychological test results, significant exaggeration. Ms. Garcia remains quite angry at the bank which foreclosed on her home. This is understandable, but is not a psychological disorder. She may also have mild cognitive impairments relative to her best lifetime capability, but this is speculative, obscured by exaggeration and emotional overlay and unrelated to her litigation claims.

Ms. Garcia would benefit greatly from significant changes in her treatment strategy, as outlined in this report. Her current litigation is reifying and amplifying any adjustment problems she may have experienced around the time of the bank foreclosure. When there is closure with respect to litigation outcome, any litigation-based reification of her earlier Adjustment Disorder symptoms will remit. To a reasonable standard of neuropsychological and psychological certainty, drug detoxification, psychiatric medication evaluation by a board certified psychiatrist, behavioral pain management, treatment of sleep apnea (if appropriate), and physician-supervised exercise (if not medically contraindicated), will significantly reduce Ms. Garcia's chronic progressive pain, headache and mood, and improve her general state of well-being. Maintaining status quo treatments will predict further worsening of her clinical and emotional status.

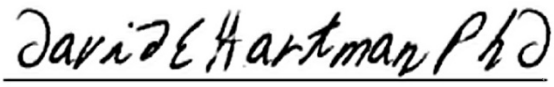
DIAGNOSES (ICD-10): F43.2 Adjustment disorder associated with litigation-based stressor. F06.34 Mood disorder due to known physiological condition with mixed features; T88.7 Unspecified adverse effects of drug or medicament; F19.20 Polysubstance prescription drug dependence; F19.94 Mixed psychoactive substance dependence with psychoactive substance-induced mood disorder; F45.42 Pain disorder with related psychological factors; G44.41. Drug-induced headache, intractable; F45.0 Somatization disorder.

While there are objective features of malingered and exaggerated symptom display, Ms. Garcia's severe and fluctuating symptoms predate her financial concerns. She is prone to amplify and express her psychological symptoms as physical-sounding infirmities, viewing depression or similar symptoms as moral weakness, and this predates her mortgage-related stress. She would be vulnerable to shaping her symptoms for litigation as a result of premorbid personality traits and symptom expression, as well as secondary gain reinforcement. It does not appear to be the case that malingering is a primary diagnosis, but rather, that exaggerated symptom display is a general personality trait encouraged by litigation.

Ms. Garcia's combination of mismanaged treatment and exaggeration indicates that she will not benefit from her current treatment. Her emotional display, headache and whole body pain symptoms are caused and worsened by her current medication treatment. So-called fibromyalgia treatment is ineffective and has worsened and extended her symptoms. Unless Ms. Garcia's entire treatment strategy is changed, symptoms will continue and progressively worsen.

Unless otherwise stated, all opinions in this report are made to a reasonable standard of neuropsychological and psychological certainty. I reserve the right to extend and amend current opinions if additional information is presented for my review. Thank you for the opportunity to provide consultation on this very interesting case.

Sincerely,



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Appendix I (CV): DAVID E. HARTMAN PHD MS ABN ABPP

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e-mail: [redacted], [redacted]

PROFESSIONAL LICENSE AND CERTIFICATION:

Licensed Psychologist: Illinois License 071-003149
National Register of Health Providers in Psychology: #33572
Diplomate: American Board of Professional Neuropsychology (ABN), 1994
Fellow: American College of Professional Neuropsychology (ACPN), 1995
Fellow: National Academy of Neuropsychology.
Diplomate: American Board of Professional Psychology (ABPP) Clinical, 2006

EDUCATION:

M.S.	Psychopharmacology, Alliant University, 12/15/2013
Ph.D.	Clinical/Cognitive Psychology, University of Illinois at Chicago, 1982. Dissertation: Structures and strategies of cognition in depression.
M.A.	Cognitive Psychology, Princeton University, 1977.
A.B.	Vassar College, Phi Beta Kappa, Departmental and General Honors, 1975.

CLINICAL AND TEACHING EXPERIENCE:

1982-present	**Private practice of clinical, forensic and medical neuropsychology and clinical psychology**
2000-2002	Neuropsychological and psychological consultant to **the Isaac Ray Center for Psychiatry and Law**. Rush Presbyterian St. Lukes' Hospital, Chicago, Illinois
1992-2000	**Isaac Ray Center for Psychiatry and Law,** Clinical Director: **Rush Human Performance Lab,** Rush Presbyterian St. Luke's Hospital, Chicago, Illinois.
1982-92	**Cook County Hospital** Director of inpatient and outpatient hospital neuropsychological services; Coordinator of the Adult Clinical Psychology Internship program;, Chicago, Illinois.
1985-86	Director of Training in Psychology, Supervising Psychologist, The **Lincoln Park Clinic at Columbus Hospital**, Chicago, Illinois.
1982	Assistant Coordinator: Emergency Psychiatry. **Northwestern Memorial Hospital**, Chicago, Illinois.
1981-82	Psychology residency: **Michael Reese Hospital and Medical Center**, Chicago, Illinois.
1981-82	Consultant: **Illinois Masonic Hospital:** Developmental Disabilities Clinic Down Syndrome Research Project, Chicago, Illinois.

TEACHING EXPERIENCE (cont.):

1979-81 Medical Psychotherapist: Department of Transplantation Surgery, **University of Illinois Medical Center**, Chicago, Illinois.

1993-2000 Instructor in psychological testing methods and psychotherapy to Rush Presbyterian St. Luke's Hospital psychiatry residents.

1990-1995 Adjunct Associate Professor of Psychiatry and Behavioral Sciences, Chicago Medical School. Teaching and supervision of psychiatry residents.

1987-92 Neuropsychology Internship Seminar. Teaching and supervision of psychology interns. Illinois State Psychiatric Institute (ISPI).

1987 Graduate Seminar in Clinical Neuropsychology. Department of Psychology, Illinois Institute of Technology (IIT).

1985-86 Clinical Practice and Theories of Psychoanalytic Psychotherapy. Full year graduate level course for the Columbus Hospital, Lincoln Park Clinic Externship Program in Clinical Psychology and Social Work. Chicago, Illinois.

1984-92 Adjunct Assistant Professor of Psychology, Department of Psychiatry, University of Illinois College of Medicine at Chicago. Chicago, Illinois.

1983-92 Theory and Practice of Clinical Neuropsychology, Graduate course for psychology interns and invited participants. Cook County Hospital.

1982-92 Brief seminars: taught at Cook County Hospital for the psychology internship program, including introductions to: Self Psychology, Hypnosis, Rorschach Exner System & Stress Management.

FORENSIC EXPERIENCE:

Expert witness: Clinical, Forensic and Medical Neuropsychology; Civil and Criminal Consultation; behavioral toxicology; Clinical psychology.

1992-2010 Consultant; *Cavanaugh & Associates*, Neuropsychological and general psychological consultant in civil forensic psychological cases.

TESTS: **Hartman, D. E., and Reynolds, C. (May 2019) TRAILS-X, Boca Raton, Fl. *Psychological Assessment Resources.***

PUBLICATIONS: (BOOKS)

Hartman, D. E. (1995). *Neuropsychological Toxicology: Identification and Assessment of Human Neurotoxic Syndromes 2nd Edition.* New York: Springer Publications. (First edition published by Pergamon Press in 1988).

BOOK CHAPTERS:

Hartman, D. E. (2018). Early evolution and forgotten founders of clinical neuropsychology. In, W. Barr (Ed.) *Oxford Handbook on the History of Neuropsychology*.

Hartman, D. E. (2018). Evolution, forensic implications and future of somatic symptom disorders. In S. Bush, G. Demakis & M. Rohling (Eds.). *Handbook of Forensic Neuropsychology.*

Hartman, D. E. (2018). Differential Diagnosis in Neuropsychology: A Strategic Approach. In J. Morgan & J. Ricker (Eds.) *Textbook of Clinical Neuropsychology,* 2nd Edition.

Hartman, D. E. (2000). Neuropsychology and the (Neuro) Toxic Tort. In J. Sweet (Ed.), *Forensic Neuropsychology: Fundamentals and Practice.* Swets.

Hartman, D. E. (1998). Missed Diagnoses and Misdiagnoses of Environmental Toxicant Exposure: The Psychiatry of Toxic Exposure and Multiple Chemical Sensitivity. *Psychiatric Clinics of North America, 21,* 659-669

Hartman, D. E. (1998). Inhalants: Behavioral Pharmacology. In R. E. Tarter, R. A. Ammerman & P. J. Ott (Eds.) *Handbook of Substance Abuse: Neurobehavioral Pharmacology,* Plenum Press.

Hartman, D. E. (1996). Ecological validity and the evolution of clinical neuropsychology. In. R. Sbordone (Ed.), *Ecological Validity and Clinical Neuropsychology.* St. Lucie Press.

Hartman, D. E., and Hessl, S., and Tarcher, A. (1992). Neurobehavioral evaluation of environmental toxin exposure: Rationale and Review. In A. Tarcher (Ed.). *Principles and Practice of Environmental Medicine*. Plenum Press.

Hartman, D. E. (1992). Neuropsychological toxicology. In A. Puente and B. McCaffrey (Eds.) *Handbook of Neuropsychological Assessment,* Plenum Press, 485-507.

Hartman, D. E. and Kleinmuntz, B. (1991). Computers in psychological practice: Historical and current uses. In J. Sweet, R. Rozensky and Tovian (Eds.). *Handbook of Clinical Psychology in Medical Settings.* Plenum Press.

Hartman, D. E. (1990). The computerized clinician: Ethical, legal and professional issues in the use of psychological software. In E. Margenau (Ed.). *The Encyclopedic Handbook of Private Practice.* Gardner Press.

ARTICLES:

Flaro, L., Gervais, R., Hartman, D. E. and Rohling, M. (in press). Paul Green (1951-2020): A tribute. *Developmental Neuropsychology.*

Hartman, D. E. (2010). "*I am the very model of a modern expert witness.*" Book Review: Forensic Neuropsychology Casebook, R. Heilbronner (Ed.). *Journal of Clinical and Experimental Neuropsychology, 32,* 445-447.

ARTICLES (cont.):

Hartman, D. E. (2009). Test Review: Wechsler Adult Intelligence Scale IV: Return of the Gold Standard. *Applied Neuropsychology, 16,* 85-87

Hartman, D. E. (2008). Test Review: The Computerized Test of Information Processing (CTIP) by Tom Tombaugh, *15,* 226-227.

Hartman, D. E. (2008). Test Review: The Iowa Gambling Task: Not just another 12 step program. *Applied Neuropsychology, 15,* 158-159.

Hartman, D. E. (2008). Test Review: Test Sematary: Koppitz-2 Developmental Scoring System for the Bender Gestalt Test, *Applied Neuropsychology*, 15, 94 - 95

Hartman, D. E. (2007). Test Review: The Test of Memory and Learning -2, *Applied Neuropsychology, 14,* 3-7-309.

Hartman, D. E. (2007) Test Review: The Wide Range Assessment of Memory and Learning (WRAML-2), *Applied Neuropsychology, 14, 138-140.*

Hartman, D. E. (2006). "The Weight is Over." Test Review: The Neuropsychological Assessment Battery (NAB). *Applied Neuropsychology, 13,* 58-61.

Hartman, D. E. (2006). "And now for something (almost) completely different": Book Review: Forensic Neuropsychology: A Scientific Approach by Glenn J. Larrabee (Ed.). (Book Review). *Applied Neuropsychology.*

Hartman, D. E. (2002). "The unexamined lie is a lie worth fibbing": Neuropsychological malingering and the Word Memory Test. *Archives of Clinical Neuropsychology, 17,* 709-714

Hartman, D. E. (April 20, 2001). On Beyond Arsenic: Child Neurotoxic Exposure. *Mealey's Emerging Toxic Torts*, King of Prussia, PA

Ruffalo, CA, Gouvier, WD, Pinkston, JB, Tucker, KA, Hartman, DE, Dahlgren, JG, & Parker, FM (in press). Ethylene dichloride: Neuropsychological effects of chronic exposure. (abstract). *Archives of Clinical Neuropsychology*.

Hartman, D. E. (May 5 2000). Poisoned Minds: Understanding and evaluating neurotoxic brain damage claims. . *Mealey's Emerging Toxic Torts*, King of Prussia, PA

Reissman, D. B., Orris, P., Lacey, R. and Hartman, D. E. (1999). Downsizing, Role Demands and Job Stress. *Journal of Occupational and Environmental Medicine. 41(4):289-293.*

Caruso, L. S. and Hartman, D. E. (Book Review, 1999). Detection of malingering during head injury Litigation. C.E. Reynolds, (Ed.). Plenum Press. *Journal of Forensic Neuropsychology, 1,* 59-66.

Caruso, L. S. and Hartman, D. E. (Book Review, 1998). The practice of forensic neuropsychology. R. J. McCaffrey, A. D. Williams, J. M. Fisher, and L. C. Laing (Eds.), *Archives of Clinical Neuropsychology*

ARTICLES (cont.):

Haywood, T. W., Hartman, D. E., Fletcher, T. A., & Kravitz, H.M. (1997). Response bias and cognitive performance in alleged impaired professionals (abstract). *The Clinical Neuropsychologist, 12,* 272.

Orris, P., Hartman, D. E., Strauss, P., Anderson, R. J., Collins, J., Knopp, C., Xu, X., and Melius, J. (1997). Stress Among Package Truck Drivers. *American Journal of Industrial Medicine, 31,* 202-210.

Laatsch, L., Hartman, D. E., and Stone, J. L. (1994). Neuropsychological evidence of amnesia following excision of an intraventricular tumor using a transcallosal approach: Interaction with alcohol abuse. *Journal of Neurology, Neurosurgery and Psychiatry*

Hartman, D. E. (1992). (Book Review) Residual Effects of Abused Drugs: NIDA Research Monograph 101, *Archives of Clinical Neuropsychology, 7*, 467-470.

Hartman, D. E. (1991). Reply to Reitan: Unexamined premises and the evolution of clinical neuropsychology. *Archives of Clinical Neuropsychology. 6,* 147-166

Hartman, D. E. (1988). Neuropsychology and the neurochemical lesion: Evolution, applications and extensions. *NeuroToxicology. 9,* 401-404.

Hartman, D. E. (1988). Book Review: Medical Neuropsychology: The Impact of Disease on Behavior., R. E. Tarter, D. H. Van Thiel & K. L. Edwards (Eds.). *Archives of Clinical Neuropsychology, 3*, 299-301.

Hartman, D. E. (1987). Neuropsychological Toxicology: Identification and assessment of neurotoxic syndromes. *Archives of Clinical Neuropsychology, 2,* 45-65.

Hartman, D. E., and Powsner, S. M., (1987). Identification with a brain-damaged parent: Theoretical considerations on a case of self-mutilation. *Psychoanalytic Psychology, 4,* 171-178.

Hartman, D. E. (1986). Artificial intelligence or artificial psychologist?: Conceptual issues in clinical microcomputer use. *Professional Psychology: Research and Practice, 17,* 528-534.

Hartman, D. E. (1986). On the use of clinical psychology software: Practical, legal and ethical concerns. *Professional Psychology: Research and Practice, 17,* 462-465.

Hartman, D. E. (1986). Book Review: Understanding Brain Damage, by K. Walsh, *Archives of Clinical Neuropsychology, 1,* 31-33.

Hartman, D. E., Sweet, J. & Elvart, A. (1985). Neuropsychological effects of Wernicke's encephalopathy as a consequence of hyperemesis gravidarum: A case study. *International Journal of Clinical Neuropsychology, 7,* 204-207.

Strauss, B., Hartman, D. E., and Soper, H. (1985). Cautions in alternate form presentation of aural test material: Speech sounds perception test. *Perceptual and Motor Skills, 61,* 899-902.

Hartman, D. E. and Bonecutter B. E. "Mixed Blessing." [letter to the editor] *APA Monitor,* August, 1984.

PAPERS & PRESENTATIONS:

Green, J., Messer, M., Hartman, D. E., and Reynolds, C. (2019). Trails-X Trail-level performance using the Profile Variability Index. Poster Presentation: *National Academy of Neuropsychology*, Annual Conference, November 13-16.

Green, J., Messer, M., Hartman, D. E. and Reynolds, C. (2019). The Trails-X: Development and validation of a novel trail-making test. Presented at the April 12-14 2019 Poster session of the *American Academy of Pediatric Neuropsychology* (AAPdN), Las Vegas NV.

Hartman, D. (2013). Low Level Lead Poisoning: The More We Know, the Lower We Go. Presented at the Annual Meeting of the American Academy of Clinical Neuropsychology, Chicago, IL, 6/20/13.

Denney, R., Hartman, D., Larrabee, G., and Boone, K. (2011). Forensic Grand Rounds. *National Academy of Neuropsychology,* Marco Island, FL. 11/17/2011

Hartman, D. E. (Chair), Rohling, M. and Spector, J. (2009). Toxicology for Neuropsychologists: Poisonous Principles, Morbid Methodology and Fatal Forensic Flaws. Invited panel presentation to the 2009 annual meeting of the American Academy of Clinical Neuropsychology (AACN), Chicago, IL.

Hartman, D. E. (2009). A Very Gorey Introduction to the Principles of Toxicology. Invited presentation to the 2009 annual meeting of the American Academy of Clinical Neuropsychology (AACN), Chicago, IL

Hartman, D. E. (2008). Arsenic to Zinc: An Alphabetical Introduction to the Principles of Toxicology. Invited Presentation to the British Psychological Society, London, England, November 5, 2008.

Pipkin, S. P., Denney, R. L., and Hartman, D. E. (October 25, 2008). Detecting exaggeration in neurocognitive dysfunction: Predicting Word memory Test and Fake Bad Scale classification with the Structured Inventory of Malingered Symptomatology. Presented at the *National Academy of Neuropsychology, 28th Annual Conference,* New York City, New York.

Hartman, D. E. (2008). Multiple Chemical Sensitivity, Postconcussion Syndrome and Bleeding Edge Disorders. Invited presentation to the British Psychological Society, London, England, November 5 2008.

Hartman, D. E. (2008). Post Traumatic Stress Disorder. Chicago Bar Association Invited Presentation, May 30, 2008, Chicago, Illinois.

Hartman, D. E. (2007). Traumatic Brain Injury: Epidemiology, Return to Work and Distinguishing Disability from Dissimulation. Invited presentation to the Fifth Annual Mid-Atlantic Regional Conference on Occupational Medicine (MARCOM), sponsored by the Maryland College of Occupational and Environmental Medicine and the Philadelphia Occupational and Environmental Medicine Society, with support from the Johns Hopkins/NIOSH Education and Research Center. Saturday, October 13, 2007, Johns Hopkins School of Nursing.

Hartman, D. E., (Chair and Panel Member) Ewbank, J., Courtney, J., Forest, B. & Reynolds, C. (October 26, 2006). "War of the Words: Surviving the Neuropsychological Deposition. Presented at the Annual Meeting of the *National Academy of Neuropsychology,* San Antonio Texas.

Hartman, D. E. (May 21, 2007): Introduction to objective assessment of symptom self-report and cognitive malingering assessment. Presented at the Annual Meeting of the *American Psychiatric Association,* San Diego, California.

Hartman, D. E. (May 25, 2006). Advances in the Evaluation of Neuropsychological Malingering. Presented at the Annual Meeting of the *American Psychiatric Association,* Toronto, Canada.

Hartman, D. E. (May 26, 2005). Basic principles and evaluation strategies to detect cognitive malingering. Presented at the annual meeting of the *American Psychiatric Association,* World Conference Center, Atlanta Georgia.

Hartman, D. E. (March 14 2005). Recommendations and Critique of Welding Rod Manganese Neurotoxicity Research. Invited lecture presented at the second *Mealey's Welding Rod Litigation Conference,* Phoenix Arizona, Ritz Carlton Hotel.

Hartman, D. E. (October 7 2004). *The Rules: Interpreting Forensic Neuropsychological Research.* Invited lecture presented at the Mealey's Welding Rod Litigation Conference, Palm Springs, Florida, Four Seasons Hotel.

Hartman, D. E. (May 6, 2004). *Neuropsychological Malingering.* Invited lecture presented to the Annual Meeting of the *American Psychiatric Association,* Jacob Javits Center, New York City, New York.

Hartman, D. E. (April 28 2004). *Medical Mysteries: Understanding Multiple Chemical Sensitivity as a template for evaluating science and clinical diagnosis in subjective medical disorders.* Presented at the PDC Disability Experts Forum, San Destin, Florida.

Hartman, D. E. (Saturday September 6, 2003) Cause and *Defect:* Clinical versus Laboratory Causation in Neurotoxic Exposure. Invited address to NAACT: North American Congress of Clinical Toxicology, Chicago, Illinois.

Hartman, D. E. (May 9 2001). Understanding and detecting cognitive malingering. Invited presentation to the annual meeting of the *American Psychiatric Association,* New Orleans, LA.

Hartman, D. E. (Nov 2000) Pediatric Neuropsychological Toxicology. Invited 3 hour teaching seminar to the 2000 Meeting of the National Academy of Neuropsychology, Orlando, Florida

Hartman, D. E. (May 30 2000) Neuropsychological Evaluation of Traumatic Brain Injury. Presented to the CONCENTRA Organization, Rosemont, Illinois.

Hartman, D. E. (May 15 2000). Detection of Neuropsychological Malingering. Presented at the annual meeting of the *American Psychiatric Association*, Chicago, Illinois

Hartman, D. E. (2000) Pediatric and Developmental Neuropsychological Toxicology. Presented at the World Conference of Pediatric Neuropsychology. Fielding Institute and The Menninger Clinic, Saturday, January 21, 2000. Santa Barbara, California

PAPERS & PRESENTATIONS:

Hartman, D. E., Haywood, T. W., Sivan, A. B., and Kravitz, H. M. Sensitivity of Microcog in assessing cognitive impairment among impaired professionals. Presented at the 107th annual meeting of the American Psychological Association, Boston, Massachusetts, August 23rd, 1999.

Hartman, D. E. (1999) Neuropsychological evaluation and prediction of traumatic brain injury sequelae. Invited Presentation to Medical Evaluation Systems, Schaumburg, Illinois, May 11, 1999.

Fletcher, T., Hartman, D. E., and Cavanaugh, J. Fitness for duty: A multi-modal approach. Presented at the 1998 meeting of the American Academy of Psychiatry and Law (AAPL), 10/24/98, New Orleans, LA.

Haywood, T. W., Hartman, D. E., Fletcher, T. A., and Kravitz, H. Response bias and cognitive performance in alleged impaired professionals. Presented at the August 1998 annual meeting of the American Psychological Association, San Francisco, CA.

Fletcher, T. A., Hartman, D. E., Haywood, T. W., & Cavanaugh, J. L. Fitness for duty: A multi-modal approach. Presented at the 1998 Annual Meeting of the American Academy of Psychiatry and the Law, New Orleans, LA October 24, 1998.

Hartman, D. E. The use of neuropsychological methods in fitness for duty examinations. Presented at the 1997 meeting of the American Academy of Psychiatry and Law (AAPL), November 1997, Denver CO

Hartman, D. E. Differential Diagnosis of a New Yorker. Multi-disciplinary grand rounds case conference. Rush Presbyterian St. Luke's Medical Center, Chicago, Illinois, September 17, 1997.

Hartman, D. E. Neuropsychological Evaluations in Workplace Violence Assessment: Paper presented in the symposium "Violence in the Workplace: New Challenges," (J. L. Cavanaugh, Chairman), at the American Psychiatric Association 48th Institute on Psychiatric Services, October 22, 1996.

Hartman, D. E. They Say They Can Work But What Will Happen If I Send Them Back?: Neuropsychological Evaluation of Fitness for Duty in Professionals. Paper presented to the 1996 National Peer Assistance Network for Nurses (PANN) Conference, Arlington Heights, Illinois, March 22, 1996.

Hartman, D. E. The Neuropsychology of Childhood Lead Exposure. Invited teaching seminar to the Department of Psychology, Children's Memorial Hospital, March 8, 1996, Chicago, Illinois

Hunter, S. J., Sivan, A. B., Hartman, D. E., Kravitz, H., & Cavanaugh, J. (1996). When low average means impaired: Evaluating the neuropsychological status of professionals. Presented to the International Neuropsychological Society, Chicago, IL. February, 1996.

Hartman, D. E., Multiple Chemical Sensitivity: Symptoms in Search of a Science. Invited presentation to the Board of Directors: Workers' Compensation Board, Halifax, Nova Scotia, December 6, 1995.

Hartman, D. E., Neuropsychological Toxicology 1995: Review and Development. Three hour teaching workshop presented at the 15th Annual Conference of the *National Academy of Neuropsychology,* November 2, 1995.

PAPERS & PRESENTATIONS:

Hartman, David E., Hunter, Scott J., Sivan, A. B., Kravitz, H. M. and Cavanaugh, J.C. Neuropsychologic test sensitivity in professionals. Paper presented to the American Academy of Psychiatry and the Law, Seattle Washington, October 19, 1995.

Hartman, D. E. Neurotoxic Disorders and the Neuropsychology of Abused Drugs (co-presented with T. Strickland, Ph.D.) Invited program presented to the *National Academy of Neuropsychology,* 14th Annual Conference, November 3, 1994, Orlando, Florida.

Hartman, D. E. Neurobiology and Neuropsychology of Drugs of Abuse: Implications for Assessment and Treatment (co-presented with T. Strickland, Ph.D.). Invited program presented to the *National Academy of Neuropsychology* 13th Annual Conference, October 29, 1993, Phoenix, Arizona.

Hartman, D. E. Neuropsychological Toxicology, 1994. Invited address to the annual meeting of the *Colorado Neuropsychological Society*, Boulder Colorado, October 8, 1993.

Hartman, D. E. Differential diagnosis of neurotoxic disorders, multiple chemical sensitivity and sick building syndrome. Presented at the annual meeting of the American Congress of Allergy and Immunology, Chicago, Illinois, November 13, 1992.

Strickland, A., Hartman, D. E., and Satz, P. (1991). Neuropsychological consequences of crack cocaine abuse. Presented at the 11th annual meeting of the *National Academy of Neuropsychology*, Dallas, Texas.

Hartman, D. E. Introduction to the Neuropsychological Evaluation of Neurotoxic Disorders. University of Chicago Hospitals, Department of Psychiatry, Clinical Neurosciences Series, January, 11, 1991

Hartman, D. E. Cognitive and Behavioral Effects of Neurotoxins on Brain Status and Methods of Neuropsychological Assessment. Presented at the 1990 Annual Meeting of the American Bar Association, Section of Science and Technology, Session on Brain Damage Claims, August 5, 1990, Chicago, Illinois.

Hartman, D. E. Private Practice in Neuropsychological Toxicology. Presented at the July 1990 Meeting of the American Psychological Association: Boston, Mass.

Hartman, D. E. Overview of Current Research of Neurotoxic Effects of Industrial Chemicals. Presented at the 1989 Cuban-United States Colloquium on Occupational Disease — Neurotoxicity of Industrial Chemicals, November 13, 1989, Havana, Cuba.

Hartman, D. E. Differential Diagnosis of Functional versus Neurotoxic Disorder using Neuropsychiatric Methods. Presented at the 1989 Cuban-United States Colloquium on Occupational Disease - Neurotoxicity of Industrial Chemicals, Nov. 13, 1989, Havana, Cuba.

Hartman, D. E. Chronic neuropsychological effects of industrial chemicals and abused drugs. Presented at the third annual Topics in Emergency Medicine: Toxicology, MESA Education and Research Foundation. 10/29/88, Chicago, Illinois

Hartman, D. E. Neuropsychological Toxicology. Presented at the 7th Annual meeting of the National Academy of Neuropsychologists (NAN), October 28, 1987.

PAPERS & PRESENTATIONS:

Hartman, D. E. Neuropsychological effects of neurotoxic substances. Presented at the 5th Anniversary International Neurotoxicology Conference, October, 2, 1987, Little Rock, Arkansas.

Hartman, D. E. Neuropsychological toxicology: Identification and neurobehavioral testing of solvent-exposed workers. Presented at the Midwest Regional Meeting of the American Public Health Association Occupational Health Section, June 6, 1987.

Hartman, D. E. Absolutely essential aspects of computerizing psychological service: Ethics, Legality & Practicality. Presented at the 1986 annual meeting of the Illinois Psychological Association, November 14, Chicago, Illinois.

Hartman, D. E. Neuropsychological toxicology: Neurobehavioral effects of toxic substances. Paper presented at the 1986 annual meeting of the Illinois Psychological Association, November 15, Chicago, Illinois.

Hartman, D. E. Neuropsychological toxicology: Effects of metals, solvents, pesticides and other nervous system poisons. Presented at the 10/27/86 annual meeting of the National Academy of Neuropsychology (NAN) Las Vegas, Nevada.

Sweet, J. & Hartman, D. E. Neuropsychological manifestations of Acquired Immunodeficiency Syndrome (AIDS): A case study. Presented at the 1986 annual meeting of NAN. October 27-29, Las Vegas, Nevada.

Hartman, D. Neuropsychological toxicology: The effects of industrial substances on brain and behavior. Presented at the 1986 annual meeting of the Chicago Area Council on Occupational Safety and Health (CACOSH) 10/11/86

Hartman, D. Neurotoxic effects of job chemicals. Paper presented at the Chicago Area Council of Occupational Safety and Health, (CACOSH) 3/27/85

Hartman, D., Sweet, J. & Elvart, A. A case study of the neuropsychological effects of Wernicke's encephalopathy induced by hyperemesis gravidarum. Presented at the 1984 annual meeting of the National Academy of Neuropsychologists, October 24-26, San Diego, CA.

Hartman, D. E. Neuropsychological effects of neurotoxic substances. Presented at the Midwestern Neuropsychology Group, Chicago, Illinois, 1984.

Hartman, D. E., & McKirnan, D. Risky decision in depression: Sad schemas produce unexpected utility values. Presented at the 1983 annual meeting of the American Psychological Association Anaheim, CA.

Hartman, D. E. and Malecki, M. Psychological aspects of renal transplantation (video seminar). Dep't. of Transplantation Surgery, University of Illinois Medical Center, Chicago, Illinois, 1981.

Glucksberg, S., Hartman, D. and Stack, R. Metaphoric comprehension is an automatic and parallel process. Presented at the Psychonomic Society, 1977

Hartman, D. E. Effects of semantic constraint on processing ambiguous words. Presented at the 1976 annual meeting of the American Psychological Association, Washington, D.C.

PAST AND CURRENT MEMBERSHIPS: *National Academy of Neuropsychology* (NAN), *International Neuropsychology Society* (INS), *Psychoanalytic Study Group*, Michael Basch, M.D. (1988-1989), *Self Psychology Study Group*, Ernest Wolf, M.D. and Marian Tolpin, M.D. (1990-1998)

HONORS:

Chair: Information Technology (IT) *National Academy of Neuropsychology 2006-2007* Associate Journal Editor: *Test Reviews Journal of Applied Neuropsychology, 2006-2010* Who's Who in Medicine and Health Care 1st & 2nd Editions; Who's Who in America; Who's Who in the World; Who's Who in Science and Engineering; Who's Who in the Midwest, Who's Who Among Human Service Professionals Grant Proposal National Institute on Drug Abuse (NIDA). Reviewer:Proposal N43DA-7-6502 Computerized Neuropsychological Testing Software Examiner: American Board of Professional Neuropsychology (ABPN) Fellow: American College of Professional Neuropsychology(ACPN), 1995 Fellow: National Academy of Neuropsychology (NAN), 1990.

HONORS (Editorial Board): *Applied Neuropsychology, 2016-; Journal of Forensic Neuropsychology, 1997-2007; The Professional Neuropsychologist, 1997-2007 Neuropsychology Review 1996-2007 Archives of Clinical Neuropsychology,* 1987-1990; 1998-2008

CHAIRPERSON:

Toxicology Presentations: 1998 Annual Meeting of the International Neuropsychological Society (INS), Oahu, Hawaii.

Workplace Violence: Program presented at the annual meeting of the Illinois Psychological Association, November 9 1995. Illinois Psychological Association-Clinical Division, 1986-87.

Psychoanalysis in Chicago: New Training Opportunities. Program presented at the 1986 annual meeting of the Illinois Psychological Association, November 16, 1986.

Emerging Trends in Clinical Neuropsychology. Program presented at the 1986 annual meeting of the Illinois Psychological Association, November 15, 1986.

The Automated Psychologist: Computerizing psychological services. Program presented at the 1986 annual meeting of the Illinois Psychological Association, November 15, 1986.

REVIEWER: *Archives of Clinical Neuropsychology, The Clinical Neuropsychologist, Neuropsychology, NeuroToxicology, Journal of Nervous and Mental Disease, Neuropsychology Review, Clinical Psychology in Medical Settings, New Scientist, Journal of Psychosomatic Research, Journal of Forensic Neuropsychology, Applied Neuropsychology, Journal of Clinical and Experimental Neuropsychology, Journal of Forensic Psychology Practice, International Journal of Occupational and Environmental Health, Child Neuropsychology*

FACULTY: Soc. for Clin. and Exp. Hypnosis. Workshop Series, October 19-22, 1982, Indianapolis, In.

RECIPIENT: NIMH fellowship, University of Illinois, 1978-1980; Teaching fellowship and full tuition scholarship: Princeton University, 1975-78; Vice chair, acting chair: Princeton Graduate College, Princeton, N.J. 1977-78; Recipient: National Science Foundation Fellowship Honorable Mention 1975; 1976; Vassar Fellowship (Hon.), 1975; Washburn Fellowship in Psychology (Hon.), Vassar College; Phi Beta Kappa, Vassar College, 1975.

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APPENDIX 2: Per request, the following represents my best effort to provide a case list where there may have been deposition testimony or trial, for the time specified.

01/01/2018	Carlson v. Jerousek	14 L 0264	Cray Huber Horstman
01/03/2018	Hirons v. Alammrew	1:16-Cv-920	Thomas Murray Jr. Esq.
01/18/2018	Bragar v. CTA	2015L017	Jade Simmons, CTA
02/22/2018	Carlson v. Midwest		David Farina Esq, Cray Huber
02/26/2018	Chambers v. Peoples Gas	18WC7588	Derek Storm, Garofalo Schreiber & Storm
04/10/2018	James Rigdon	17674923	Tristar
06/08/2018	Gilbert Garza	20140812	Unton Inman & Fitgibbons
06/15/2018	Rosalind Williams	15595477 DEN1L4	Genex Services
07/20/2018	Williams v. Mueller	15 L 744	Ron Aeschliman, Griffin Law
11/02/2018	Sarah Fowler	[no case # avail]	Betz/Blevin Indiana
11/08/2018	Terrance Jones	16649548	Tristar
11/09/2018	Sterba v. Summit	15L3798	Thomas Wolf Esq. Lewis Brisbois
12/21/2018	Motorola (class action)		Kelly Milam, Gordon and Rees
02/01/2019	Travis Wilhite	00667-P7915	Michael Kokal Esq. Heyl Royster
04/16/2019	Amanda Antonacci	16628864 DEN1W8	Marsha Gottleib AG, Carbondale
04/25/2019	Johnson v. Gurvich	CDC 2017-3514	Hebbler & Giordano, LLC.
08/08/2019	Steven Mantzke	18731207	Tristar
08/14/2019	Loukia Rodriguez	11488515-001	Valerie Peiler Esq., Brady Connolly & Masuda
08/16/2019	Lacretia Henderson	19WC26965	Derek Storm, Garofalo Schreiber Storm
02/26/2020	Barnard v. Toyota	2016 L 001063	Watkins & Eager
03/02/2020	Christopher Fritsche	18705144	Tristar
03/30/2020	Krystal Perdue	19L8831	Gordon Rees
08/20/2020	Rodriguez v. Simco	45D10-1702-CT-00029	Joshua Rauch, Mandel Horn & Rauch
01/06/2021	Rodney Molt	Tristar 20801212	
03/15/2021	Chansinthanawan, K.	2018 L 009973	David Sethi Esq. Smith Amundsen
03/17/2021	Michael Silk v. Well Luck	2019 L 009496	Joseph Wilson Esq. Maisel & Assoc.
04/21/2021	Doe v. Board of Ed.	17 L 280	Nielsen, Zehe & Antas
04/24/2021	Steven Winiecki	2017L012666009496	Kelly Milam, Gordon Rees Scully
08/07/2021	Bates v. Matrix	17594	Williams, Porter Day & Neville
09/06/2021	George Snure	45D02-1710-CT-102	Leahy, Eisenberg & Fraenkel
02/07/2022	Cotton v. Insperity	21WC10701	Hennessy & Roach PC
02/17/2022	Regan v. Black	2450086	Mette, Evans & Woodside

02/25/2022	Lorene Schrock	20d03-1903-ct-000061	Erie Insurance
03/30/2022	Carlos Bowman	3:15-cv-02315	Megan Murphy, IL Atty Gen'l
03/09/2022	Brittanie Hayes v. Arthur	19 L 12016	Litchfield/Cavo
04/25/2022	N.Y. v. Savinovich	003951988	Eric Kleiner Esq.